Veterans Health Care
May 2004

1: AIDS Policy Law. 2004 Apr 9;19(7):6.
Veteran with AIDS wins disability appeal.
[No authors listed]
PMID: 15124601

2: Alcohol Clin Exp Res. 2004 Mar;28(3):448-55.
Using alcohol screening results and treatment history to assess the severity of at-risk drinking in Veterans Affairs primary care patients.
Bradley KA, Kivlahan DR, Zhou XH, Sporleder JL, Epler AJ, McCormick KA, Merrill JO, McDonell MB, Fihn SD.
BACKGROUND: Primary care providers need practical methods for managing patients who screen positive for at-risk drinking. We evaluated whether scores on brief alcohol screening questionnaires and patient reports of prior alcohol treatment reflect the severity of recent problems due to drinking. METHODS: Veterans Affairs general medicine outpatients who screened positive for at-risk drinking were mailed questionnaires that included the Alcohol Use Disorders Identification Test (AUDIT) and a question about prior alcohol treatment or participation in Alcoholics Anonymous ("previously treated"). AUDIT questions 4 through 10 were used to measure past-year problems due to drinking (PYPD). Cross-sectional analyses compared the prevalence of PYPD and mean Past-Year AUDIT Symptom Scores (0-28 points) among at-risk drinkers with varying scores on the CAGE (0-4) and AUDIT-C (0-12) and varying treatment histories. RESULTS: Of 7861 male at-risk drinkers who completed questionnaires, 33.9% reported PYPD. AUDIT-C scores were more strongly associated with Past-Year AUDIT Symptom Scores than the CAGE ($p < 0.0005$). The prevalence of PYPD increased from 33% to 46% over the range of positive CAGE scores but from 29% to 77% over the range of positive AUDIT-C scores. Among subgroups of at-risk drinkers with the same screening scores, patients who reported prior treatment were more likely than never-treated at-risk drinkers to report PYPD and had higher mean Past-Year AUDIT Symptom Scores ($p < 0.0005$). We propose a simple method of risk-stratifying patients using AUDIT-C scores and alcohol treatment histories. CONCLUSIONS: AUDIT-C scores combined with one question about prior alcohol treatment can help estimate the severity of PYPD among male Veterans Affairs outpatients.
PMID: 15084903]

3: Alcohol Clin Exp Res. 2004 Feb;28(2):313-21.
The Veterans Aging Cohort Study: observational studies of alcohol use, abuse, and outcomes among human immunodeficiency virus-infected veterans.

Conigliaro J, Madenwald T, Bryant K, Braithwaite S, Gordon A, Fultz SL, Maisto S, Samet J, Kraemer K, Cook R, Day N, Roach D, Richey S, Justice A.
This article represents the proceedings of a symposium at the 2003 annual meeting of the Research Society on Alcoholism in Fort Lauderdale, FL. The organizers/chairs were Joseph Conigliaro and Amy Justice. The presentations were (1) Introduction, by Joseph Conigliaro and Tamra Madenwald; (2) Alcohol and HIV/AIDS: the importance of integrative and translational research, by Kendall Bryant; (3) Alcohol use and abuse among patients with HIV infection, by Joseph Conigliaro and Stephan Maisto; (4) Severity of comorbid alcohol use/abuse in HIV infection, by Amy Justice and Jeffrey Samet; (5) Estimating the impact of alcohol use on long-term HIV outcomes, by Scott Braithwaite and Amy Justice; (6) Homelessness, drug & alcohol use among HIV+ veterans, by Adam Gordon and Robert Cook; and (7) Hepatitis C & alcohol in the VACS 3 study, by Shawn Fultz and Kevin Kraemer. The symposium concluded with a discussion led and facilitated by Diedra Roach.
PMID: 15112939

4: Am J Health Syst Pharm. 2004 Mar 15;61(6):608-12.
Clinical effectiveness and cost-effectiveness of Helicobacter pylori testing and treatment in patients receiving long-term ulcer prophylaxis.
Skog JH, Morreale AP, Plowman BK, Rapier R, Dole S.
PMID: 15061433

5: Am J Health Syst Pharm. 2004 Mar 15;61(6):612-6.
Quantity and cost of commonly used ophthalmic solutions at a Veterans Affairs Health System.
Watanabe SL, Morreale AP, Zelman LA.
PMID: 15061434

6: BMC Med Res Methodol. 2004 Apr 17;4(1):8.
Patient recruitment to a randomized clinical trial of behavioral therapy for chronic heart failure.
Chang BH, Hendricks AM, Slawsky MT, Locastro JS.
BACKGROUND: Patient recruitment is one of the most difficult aspects of clinical trials, especially for research involving elderly subjects. In this paper, we describe our experience with patient recruitment for the behavioral intervention randomized trial, "The relaxation response intervention for chronic heart failure (RRCHF)." Particularly, we identify factors that, according to patient reports, motivated study participation. METHODS: The RRCHF was a three-armed, randomized controlled trial designed to evaluate the efficacy and cost of a 15-week relaxation response intervention on veterans with chronic heart failure. Patients from the Veterans Affairs (VA) Boston Healthcare System in the United States were recruited in the clinic and by telephone. Patients' reasons for rejecting the study participation were recorded during the screening. A qualitative sub-study in the trial consisted of telephone interviews of participating patients about their experiences in the study. The qualitative study included the first 57 patients who completed the intervention and/or the first follow-up outcome measures. Factors that distinguished patients who consented from those who refused study participation were identified using a t-test or a chi-square test. The reason for study participation was abstracted from the qualitative interview. RESULTS: We successfully consented 134 patients, slightly more than our target number, in 27 months. Ninety-five of the consented patients enrolled in the study. The enrollment rate among the patients approached was 18% through clinic and 6% through telephone recruitment. The most commonly cited reason for declining study participation given by patients recruited in the clinic was

'Lives Too Far Away'; for patients recruited by telephone it was 'Not Interested in the Study'. One factor that significantly distinguished patients who consented from patients who declined was the distance between their residence and the study site (t-test: p <.001). The most frequently reported reason for study participation was some benefit to the patient him/herself. Other reasons included helping others, being grateful to the VA, positive comments by trusted professionals, certain characteristics of the recruiter, and monetary compensation. CONCLUSIONS: The enrollment rate was low primarily because of travel considerations, but we were able to identify and highlight valuable information for planning recruitment for future similar studies.
PMID: 15090073

7: Epidemiology. 2004 Mar;15(2):135-42.
Comment in:
Epidemiology. 2004 Mar;15(2):129-30.
Gulf War veterans with anxiety: prevalence, comorbidity, and risk factors.
Black DW, Carney CP, Peloso PM, Woolson RF, Schwartz DA, Voelker MD, Barrett DH, Doebbeling BN.
BACKGROUND: Veterans of the first Gulf War have higher rates of medical and psychiatric symptoms than nondeployed military personnel. METHODS: To assess the prevalence of and risk factors for current anxiety disorders in Gulf War veterans, we administered a structured telephone interview to a population-based sample of 4886 military personnel from Iowa at enlistment. Participants were randomly drawn from Gulf War regular military, Gulf War National Guard/ Reserve, non-Gulf War regular military, and non-Gulf War National Guard/Reserve. Medical and psychiatric conditions were assessed through standardized interviews and questionnaires in 3695 subjects (76% participation). Risk factors were assessed using multivariate logistic regression models. RESULTS: Veterans of the first Gulf War reported a markedly higher prevalence of current anxiety disorders than nondeployed military personnel (5.9% vs. 2.8%; odds ratio = 2.1; 95% confidence interval = 1.3-3.1), and their anxiety disorders are associated with co-occurring psychiatric disorders. Posttraumatic stress disorder, panic disorder, and generalized anxiety disorder were each present at rates nearly twice expected. In our multivariate model, predeployment psychiatric treatment and predeployment diagnoses (posttraumatic stress disorder, depression, or anxiety) were independently associated with current anxiety disorder. Participation in Gulf War combat was independently associated with current posttraumatic stress disorder, panic disorder, and generalized anxiety disorder. CONCLUSIONS: Current anxiety disorders are relatively frequent in a military population and are more common among Gulf War veterans than nondeployed military personnel. Predeployment psychiatric difficulties are robustly associated with the development of anxiety. Healthcare providers and policymakers need to consider panic disorder and generalized anxiety disorder, in addition to posttraumatic stress disorder, to ensure their proper assessment, treatment, and prevention in veteran populations.
PMID: 15127904

8: Epidemiology. 2004 Mar;15(2):129-30.
Comment on:
Epidemiology. 2004 Mar;15(2):135-42.
War and anxiety disorders.
Vlahov D, Galea S.
PMID: 15127901

9: Health Manag Technol. 2004 Apr;25(4):30-3.
Setting safe standards. Homegrown bar coding medication administration system helps VA hospitals minimize mistakes at the point of care.
Carlson R.
PMID: 15088462

10: Issue Brief Natl Health Policy Forum. 2004 Apr 1;(796):1-20.
Veterans' health care: balancing resources and responsibilities.
Sprague L.
This paper looks at the health care benefits and services administered by the U.S. Department of Veterans Affairs. It examines management strategies adopted within the department to allocate resources, structure benefits, and improve quality. Some recommendations made by the General Accounting Office and the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans are reviewed, in particular the emphasis of the latter on increased collaboration with the Department of Defense. Long-term proposals to balance service commitments and financing also are considered.
PMID: 15101399]

11: J Acquir Immune Defic Syndr. 2004 Mar 1;35(3):253-60.
Lipid screening in HIV-infected veterans.
Korthuis PT, Asch SM, Anaya HD, Morgenstern H, Goetz MB, Yano EM, Rubenstein LV, Lee ML, Bozzette SA.
BACKGROUND: Lipid screening is recommended for patients taking protease inhibitors (PIs). METHODS: We examined data from the Veterans Administration Immunology Case Registry to assess lipid screening among HIV-infected veterans who received PIs for at least 6 consecutive months during 1999 and 2001. We estimated crude and adjusted associations between lipid screening and patient characteristics (age, gender, HIV exposure, and race/ethnicity), comorbidities (AIDS, cardiovascular disease, diabetes, hypertension, smoking, and hyperlipidemia), and facility characteristics (urban location, case management, guidelines, and quality improvement programs). RESULTS: Among 4065 patients on PIs, clinicians screened 2395 (59%) for lipids within 6 months of initiating treatment. Adjusting for patient characteristics, comorbidities, facility traits, and clustering, lipid screening was more common among patients who were cared for in urban areas (relative risk [RR] = 1.3, confidence limits: 1.0-1.5), diabetic (RR = 1.2, confidence limits: 1.1-1.3), or previously hyperlipidemic (RR = 1.4, confidence limits: 1.3-1.5) and less common among patients with a history of intravenous drug use (IVDU) (RR = 0.90, confidence limits: 0.79-1.0) or unknown HIV risk (RR = 0.85, confidence limits: 0.75-0.95). CONCLUSIONS: Six in 10 patients taking PIs receive lipid screening within 6 months of PI use. Systemic interventions to improve overall HIV quality of care should also address lipid screening, particularly among patients with unknown or IVDU HIV risk and those cared for in nonurban areas.
PMID: 15076239

12: J Am Coll Surg. 2004 May;198(5):707-16.
Breast cancer surgery trends and outcomes: results from a National Department of Veterans Affairs study.
Hynes DM, Weaver F, Morrow M, Folk F, Winchester DJ, Mallard M, Ippolito D, Thakkar B, Henderson W, Khuri S, Daley J.
BACKGROUND: This study examined trends and outcomes for breast cancer surgery performed at Department of Veterans Affairs (VA) hospitals. STUDY DESIGN: We examined breast cancer operations performed in VA hospitals from October 1991 to

September 1997. Data from the VA National Surgical Quality Improvement Program, surgical pathology reports, discharge data, and outpatient data were used. Surgical outcomes included postoperative length of stay, 30-day morbidity rates, 1-year surgery-related readmission rates, and mortality. An expert panel of breast cancer clinicians identified surgery-related hospital readmissions. Hierarchical regression analysis was used to identify patient, provider, and hospital characteristics associated with postoperative length of stay, and 30-day morbidity. RESULTS: From October 1991 to September 1997 1,333 breast operations were performed, ranging from 1 to 38 on average per hospital; 478 operations were for breast cancer. Among breast cancer surgery patients, 25% were men. Thirty-day morbidity rates, 1-year hospital readmission rates, and mortality were very low for both men and women. Postoperative length of stay averaged 6.8 days. Lower income, longer operation times, and older age increased the likelihood of 30-day morbidity. Lower functional status, older age, longer operation time, and lower average annual volume of procedures increased postoperative length of stay. Documentation of the extent of disease and surgical margin in pathology reports was poor in medical records. CONCLUSIONS: Hospital stays were longer, and morbidity and readmission rates for patients having breast cancer operations at VA hospitals were comparable to those reported for private sector hospitals.
PMID: 15110803

13: J Am Geriatr Soc. 2004 Apr;52(4):617-22.
Living alone and outpatient care use by older veterans.
Guzman JS, Sohn L, Harada ND.
In nonveteran older adults, living alone influences outpatient care use, but its importance in the veteran population has not been well studied. The aims of this study are to describe the use of outpatient care by older veterans who live alone versus those who live with others and determine whether living alone influences outpatient use by older veterans. The data come from the 2001 Veteran Identity Program Survey designed to measure Department of Veterans Affairs (VA) and non-VA outpatient care use. Univariate and bivariate analyses were conducted to examine distributional properties, associations, and subgroup differences in outpatient care use. Poisson regression was used to assess the role of living alone on outpatient care use, controlling for predisposing, other enabling, and need factors. Results found that older veterans who use the VA, whether they live alone or not, have similar numbers of VA outpatient visits. Older veterans who use VA and non-VA facilities and who live alone have greater total outpatient visits than those who live with others. Regression results indicate that living alone is a predictor of VA routine medical visits, VA prescription refill visits, and total VA and non-VA outpatient visits but does not influence VA emergency room visits. These findings suggest that living alone is associated with differences in outpatient care use by older veterans. It is important for the VA to understand this relationship with the aim of developing interventions to improve access, effectiveness, and efficiency of health services for older veterans.
PMID: 15066081

14: J Am Geriatr Soc. 2004 Apr;52(4):647-8.
Secondary prevention of hip fractures in veterans: can we do better?
Kamel HK, Bida A, Montagnini M.
PMID: 15066093]

15: J Clin Gastroenterol. 2004 Mar;38(3):279-84.

Hepatitis C tested prevalence and comorbidities among veterans in the US Northwest.
Sloan KL, Straits-Troster KA, Dominitz JA, Kivlahan DR.
GOALS: (1) Investigate the epidemiology of hepatitis C virus infection among patients seen in the Veterans Administration Northwest Network; (2) examine time trends in testing practices and results; and (3) estimate the prevalence of hepatitis C virus infection among active patients. BACKGROUND: Hepatitis C virus infection causes chronic hepatitis and cirrhosis and is a leading cause of end-stage liver disease. Hepatitis C virus antibodies are estimated to be present in 1.8% of the US population, but reports of its prevalence among US veterans range from 1.7 to 35%. STUDY: Retrospective review of computerized medical records of veterans tested for hepatitis C from October 1994 through December 2000 (n = 37,938) at 8 Northwest Veterans Administration Medical Centers. RESULTS: Among tested veterans, 8230 (21.7%) had evidence of hepatitis C virus infection. The number of patients tested increased annually from 2335 to 18,191, while the proportion with first-time positive hepatitis C test results decreased from 35 to 10%. This drop in tested prevalence was associated with a shift away from testing individuals at highest risk--those with positive hepatitis B serostatus, repeatedly elevated alanine transaminase levels, and drug use disorder diagnoses. We estimate that 11.4% of the Northwest Network veteran users are hepatitis C virus seropositive, with a lower bound of 4.0% and upper bound of 19.5%. CONCLUSIONS: Although estimates of hepatitis C virus infection rates among veteran users of the Veterans Administration system remain higher than those for the general population, changes in testing practice make generalizations from earlier studies hazardous.
PMID: 15128077]

16: J Rehabil Res Dev. 2003 Nov-Dec;40(6):vii-viii.
Diversity-Building Research Training Program.
Aisen ML.
PMID: 15077654

17: J Rehabil Res Dev. 2003 Nov-Dec;40(6):511-6.
Informal care providers for veterans with SCI: who are they and how are they doing?
Robinson-Whelen S, Rintala DH.
Veterans with spinal cord injury (SCI) who received care at the Houston Department of Veterans Affairs Medical Center were interviewed about their use of formal and informal assistance to meet their daily physical needs. Informal caregivers were found to play an important role in the daily care of veterans with SCI, with 37% receiving some informal, unpaid assistance-with personal care. Primary informal caregivers were mostly women, had a mean age of 53, and provided an average of almost 12 hours of care a day. Nearly one-third of participants rated their primary caregiver as being only in fair or poor health, and one-fourth thought their caregiver was unlikely to be able to provide the same level of care 5 years from now. Of particular concern, more than half reported that they did not have anyone else willing and able to provide assistance if their primary family caregiver became permanently unable to care for them.
PMID: 15077663

18: Rehabil Res Dev. 2003 Sep-Oct;40(5):381-95.
Development and validation of the Pain Outcomes Questionnaire-VA.
Clark ME, Gironda RJ, Young RW.
The development of effective pain treatment strategies requires the availability of precise and practical measures of treatment outcomes, the importance of which has

been noted in the Veterans Health Administration's (VHA's) National Pain Initiative. This paper presents the results of a 5-year collaborative effort to develop and validate a comprehensive and efficient self-report measure of pain treatment outcomes. Two samples of veterans (957 total subjects) undergoing inpatient or outpatient pain treatment at six VHA facilities completed Pain Outcomes Questionnaire-VA (POQ-VA) items and several additional measures. We used a comprehensive, multistage analytic procedure to evaluate the psychometric properties of the instrument. Results provided strong support for the reliability, validity, and clinical use of the POQ-VA when used to evaluate the effectiveness of treatment for veterans experiencing chronic noncancer pain.
PMID: 15080223

19: J Rehabil Res Dev. 2003 Sep-Oct;40(5):371-9.
Veterans' reports of pain and associations with ratings of health, health-risk behaviors, affective distress, and use of the healthcare system.
Kerns RD, Otis J, Rosenberg R, Reid MC.
The improved management of pain among veterans seeking care in Veterans Health Administration (VHA) facilities has been established as a priority. This study documents the high prevalence of reports of pain among a convenience sample of 685 veterans seeking care in a VHA primary care setting. Also reported are associations of pain complaints with self-rated health, an index of emotional distress, health-risk behaviors such as tobacco and alcohol use, health-related concerns about diet and weight, and perceptions of the availability of social support. The relationship between the presence of pain and use of outpatient and inpatient medical and mental health services is also examined. Nearly 50% of the sample reported that they experience pain regularly and that they were concerned about this problem at the time of the index visit to their primary care provider. Persons acknowledging the presence of pain, relative to those not reporting pain, were younger, reported worsening health over the past year, had
greater emotional distress, used tobacco, had diet and/or weight concerns, and were found to use more outpatient medical, but not inpatient medical or mental health services. Results support the goals of the VHA National Pain Management Strategy designed to reduce unnecessary pain and suffering among veterans receiving care in VHA facilities.
PMID: 15080222

20: J Rehabil Res Dev. 2003 Sep-Oct;40(5):ix-xi.
Clinical research as a foundation for Veterans Health Administration Pain Management Strategy.
Kerns RD.
PMID: 15080221

21: J Rehabil Res Dev. 2003 Sep-Oct;40(5 Suppl 2):1-12.
Smoking cessation care received by veterans with chronic obstructive pulmonary disease.
Sherman SE, Lanto AB, Nield M, Yano EM.
Smoking is the main cause of chronic obstructive pulmonary disease (COPD), and smoking cessation is the only effective intervention to slow its progression. We examined whether smokers with COPD received more cessation services than smokers without COPD. Current smokers from 18 Veterans Health Administration primary care clinics completed baseline and 12 month follow-up surveys (baseline n = 1,941; 12 month n = 1,080), composed of validated questions on smoking habits, history, and attitudes; health/functional status; and sociodemographics. Both at

baseline and 12 month follow-up, smokers with COPD were more likely to report that they had been advised to quit, prescribed nicotine patches, or referred to a smoking cessation program within the last year. However, the rate of quitting smoking was the same for smokers with COPD and smokers without COPD. The increase in cessation services received by smokers with COPD was noted primarily among smokers not interested in quitting. New approaches may be required, particularly to help smokers not interested in quitting.
PMID: 15074449

22: J Rehabil Res Dev. 2003 Sep-Oct;40(5):433-41.
Pressure ulcers in veterans with spinal cord injury: a retrospective study.
Garber SL, Rintala DH.
Pressure ulcers are a major complication of spinal cord injury (SCI) and have a significant effect on general health and quality of life. The objectives of this retrospective chart review were to determine prevalence, duration, and severity of pressure ulcers in veterans with SCI and to identify predictors of (1) outcome in terms of healing without surgery, not healing, or referral for surgery; (2) number of visits veterans made to the SCI outpatient clinic or received from home care services for pressure ulcer treatment; and (3) number of hospital admissions and days hospitalized for pressure ulcer treatment. From a sampling frame of 553 veterans on the Houston Veterans Affairs Medical Center SCI roster, 215 (39%) were reported to have visited the clinic or received home care for pressure ulcers (ICD-9 code 707.0 = decubitus, any site) during the 3 years studied (1997, 1998, and 1999). From this sample, 102 veterans met the inclusion criteria for further analyses, 56% of whom had paraplegia. The duration of ulcers varied greatly from 1 week to the entire 3-year time-frame. Overall, Stage IV pressure ulcers were the most prevalent as the worst ulcer documented. Number and severity of ulcers predicted outcome and healthcare utilization. This study illustrates the magnitude of the pressure ulcer problem among veterans with SCI living in the community. Reducing the prevalence of pressure ulcers among veterans with SCI will have a significant impact on the Department of Veterans Affairs' financial and social resources. Innovative approaches are needed to reduce pressure ulcer risk in veterans with SCI.
PMID: 15080228

23: J Rehabil Res Dev. 2003 Jul-Aug;40(4):vii-viii.
VA's national rehabilitation special events: therapy at its best.
McDowell I.
PMID: 15074439

24: JAMA. 2004 May 26;291(20):2466-70.
Pitfalls of converting practice guidelines into quality measures: lessons learned from a VA performance measure.
Walter LC, Davidowitz NP, Heineken PA, Covinsky KE.
The Department of Veterans Affairs (VA) manages the largest health care system in the United States, and the Institute of Medicine has recommended that many practices of VA quality measurement be applied to the US health care system as a whole. The VA measures quality of care at all of its sites by assessing adherence rates to performance measures, which generally are derived from evidence-based practice guidelines. Higher adherence rates are used as evidence of better quality of care. However, there are problems with converting practice guidelines, intended to offer guidance to clinicians, into performance measures that are meant to identify poor-quality care. We suggest a more balanced perspective on the use of performance measures to define quality by delineating conceptual problems with the

conversion of practice guidelines into quality measures. Focusing on colorectal cancer screening, we use a case study at 1 VA facility to illustrate pitfalls that can cause adherence rates to guideline-based performance measures to be poor indicators of the quality of cancer screening. Pitfalls identified included (1) not properly considering illness severity of the sample population audited for adherence to screening, (2) not distinguishing screening from diagnostic procedures when setting achievable target screening rates, and (3) not accounting for patient preferences or clinician judgment when scoring performance measures. For many patients with severe comorbid illnesses or strong preferences against screening, the risks of colorectal cancer screening outweigh the benefits, and the decision to not screen may reflect good quality of care. Performance measures require more thoughtful specification and interpretation to avoid defining high testing rates as good quality of care regardless of who received the test, why it was performed, or whether the patient wanted it.
PMID: 15161897

25: JAMA. 2004 May 19;291(19):2316; author reply 2316.
Comment on:
JAMA. 2004 Feb 18;291(7):882-3.
The debt repayment paradox for VA clinical investigators.
Bean-Mayberry B, Gordon AJ, Fultz SL.
PMID: 15150202

26: Laryngoscope. 2004 Mar;114(3):450-3.
Incidence of serious complications after uvulopalatopharyngoplasty.
Kezirian EJ, Weaver EM, Yueh B, Deyo RA, Khuri SF, Daley J, Henderson W.
OBJECTIVES: Uvulopalatopharyngoplasty (UPPP) is the most common surgical treatment for obstructive sleep apnea (OSA). Anatomic and physiologic abnormalities associated with OSA can make perioperative management difficult. Only single-site case series provide current estimates of the incidence of perioperative complications, with a pooled crude serious complication rate of 3.5% and a crude mortality rate of 0.4%. The primary objective of this study was to calculate the incidence of perioperative morbidity and mortality in a large, multisite cohort of UPPP patients. STUDY DESIGN: Prospective cohort study of adults undergoing inpatient UPPP with or without other concurrent procedures METHODS: The serious complication and 30-day mortality rates were calculated from the Department of Veterans Affairs (VA) National Surgical Quality Improvement Program database of prospectively collected outcomes of all VA inpatient surgeries nationally 1991 to 2001. Serious complications were defined by 15 specific life-threatening complications. Deaths were captured whether the patient was in the hospital or discharged. RESULTS: Veteran patients (n = 3130) had a mean age of 50 years and were predominantly male (97%). The serious nonfatal complication rate was 1.5% (47/3,130) (95% confidence interval [CI] 1.1%, 1.9%). The 30-day mortality rate was 0.2% (7/3130) (95% CI 0.1%, 0.4%). There was no significant effect of year of surgery or patient age on the risk of serious complication or death. CONCLUSION: The incidence of serious nonfatal complications and 30-day mortality after UPPP are 1.5% and 0.2%, respectively, in a large cohort of UPPP patients at veteran hospitals.
PMID: 15091217

27: Med Care Res Rev. 2003 Sep;60(3 Suppl):142S-145S.
Comment on:
Med Care Res Rev. 2003 Sep;60(3 Suppl):124S-141S.
Methods for patient-level costing in the VA system: are they applicable to

Canada?
Blackhouse G, Goeree R, O'Brien BJ.
PMID: 15095550

28: Med Care Res Rev. 2003 Sep;60(3 Suppl):124S-141S.
Comment in:
Med Care Res Rev. 2003 Sep;60(3 Suppl):142S-145S.
Determination of VA health care costs.
Barnett PG.
In the absence of billing data, alternative methods are used to estimate the cost of hospital stays, outpatient visits, and treatment innovations in the U.S. Department of Veterans Affairs (VA). The choice of method represents a trade-off between accuracy and research cost. The direct measurement method gathers information on staff activities, supplies, equipment, space, and workload. Since it is expensive, direct measurement should be reserved for finding short-run costs, evaluating provider efficiency, or determining the cost of treatments that are innovative or unique to VA. The pseudo-bill method combines utilization data with a non-VA reimbursement schedule. The cost regression method estimates the cost of VA hospital stays by applying the relationship between cost and characteristics of non-VA hospitalizations. The Health Economics Resource Center uses pseudo-bill and cost regression methods to create an encounter-level database of VA costs. Researchers are also beginning to use the VA activity-based cost allocation system.
PMID: 15095549

29: Med Care Res Rev. 2003 Sep;60(3 Suppl):92S-123S.
Pharmacy data in the VA health care system.
Smith MW, Joseph GJ.
Recent advances in Department of Veterans Affairs (VA) health care data systems have greatly increased access to operational pharmacy information. This article presents a brief guide to VA pharmacy data sources: the Veterans Health Information Systems and Technology Architecture files, the Pharmacy Benefits Management database, Decision Support System (DSS) National Data Extracts for inpatient and outpatient care, the planned DSS National Pharmacy Extract, DSS databases at local VA facilities, and the Non-VA Fee Basis files. Depending on the source, available data elements include patient demographics, clinical care information, characteristics of the medication and of the prescribing physician, and cost. Access policies are detailed for VA and non-VA researchers. Linking these sources to VA databases containing data on inpatient and outpatient services offers a comprehensive view of health care within several VA populations of general interest, including people over age 65 and those with physical and psychiatric disabilities.
PMID: 15095548

30: Med Care Res Rev. 2003 Sep;60(3 Suppl):74S-91S.
Direct measurement of health care costs.
Smith MW, Barnett PG.
Cost identification is fundamental to many economic analyses of health care. Health care costs are often derived from administrative databases. Unit costs may also be obtained from published studies. When these sources will not suffice (e.g., in evaluating interventions or programs), data may be gathered directly through observation and surveys. This article describes how to use direct measurement to estimate the cost of an intervention. The authors review the elements of cost determination, including study perspective, the range of elements to measure, and short-run versus long-run costs. They then discuss the advantages and drawbacks of

alternative direct measurement methods such as time-and-motion studies, activity logs, and surveys of patients and managers. A parsimonious data collection effort is desirable, although study hypotheses and perspective should guide the endeavor. Special reference is made to data sources within the Department of Veterans Affairs (VA) health care system.
PMID: 15095547

31: Med Care Res Rev. 2003 Sep;60(3 Suppl):146S-167S.
Prevalence and costs of chronic conditions in the VA health care system.
Yu W, Ravelo A, Wagner TH, Phibbs CS, Bhandari A, Chen S, Barnett PG.
Chronic conditions are among the most common causes of death and disability in the United States. Patients with such conditions receive disproportionate amounts of health care services and therefore cost more per capita than the average patient. This study assesses the prevalence among the Department of Veterans Affairs (VA) health care users and VA expenditures (costs) of 29 common chronic conditions. The authors used regression to identify the marginal impact of these conditions on total, inpatient, outpatient, and pharmacy costs. Excluding costs of contracted medical services at non-VA facilities, total VA health care expenditures in fiscal year 1999 (FY1999) were $14.3 billion. Among the 3.4 million VA patients in FY1999, 72 percent had 1 or more of the 29 chronic conditions, and these patients accounted for 96 percent of the total costs ($13.7 billion). In addition, 35 percent (1.2 million) of VA health care users had 3 or more of the 29 chronic conditions. These individuals accounted for 73 percent of the total cost. Overall, VA health care users have more chronic diseases than the general population.
PMID: 15095551

32: Med Care Res Rev. 2003 Sep;60(3 Suppl):37S-39S.
Comment in:
Med Care Res Rev. 2003 Sep;60(3 Suppl):15S-36S.
Estimation of encounter-level hospitalization costs: accuracy of a multivariate prediction model.
Malkin JD, Schoenbaum M.
PMID: 15095544]

33: Med Care Res Rev. 2003 Sep;60(3 Suppl):15S-36S.
Comment on:
Med Care Res Rev. 2003 Sep;60(3 Suppl):37S-39S.
Using average cost methods to estimate encounter-level costs for medical-surgical stays in the VA.
Wagner TH, Chen S, Barnett PG.
The U.S. Department of Veterans Affairs (VA) maintains discharge abstracts, but these do not include cost information. This article describes the methods the authors used to estimate the costs of VA medical-surgical hospitalizations in fiscal years 1998 to 2000. They estimated a cost regression with 1996 Medicare data restricted to veterans receiving VA care in an earlier year. The regression accounted for approximately 74 percent of the variance in cost-adjusted charges, and it proved to be robust to outliers and the year of input data. The beta coefficients from the cost regression were used to impute costs of VA medical-surgical hospital discharges. The estimated aggregate costs were reconciled with VA budget allocations. In addition to the direct medical costs, their cost estimates include indirect costs and physician services; both of these were allocated in proportion to direct costs. They discuss the method's limitations and application in other health care systems.
PMID: 15095543

34: Med Care Res Rev. 2003 Sep;60(3 Suppl):40S-53S.
Average cost of VA rehabilitation, mental health, and long-term hospital stays.
Yu W, Wagner TH, Chen S, Barnett PG.
This article describes the development of a database for the cost of inpatient rehabilitation, mental health, and long-term care stays in the Department of Veterans Affairs from fiscal year 1998 forward. Using "bedsection," which is analogous to a hospital ward, the authors categorize inpatient services into nine categories: rehabilitation, blind rehabilitation, spinal cord injury, psychiatry, substance abuse, intermediate medicine, domiciliary, psychosocial residential rehabilitation, and nursing home. For each of the nine categories, they estimated a national and a local (i.e., medical center) average per diem cost. The nursing home average per diem costs were adjusted for case mix using patient assessment information. Encounter-level costs were
then calculated by multiplying the average per diem cost by the number of days of stay in the fiscal year. The national cost estimates are more reliable than the local cost estimates.
PMID: 15095545

35: Med Care Res Rev. 2003 Sep;60(3 Suppl):54S-73S.
Estimating the costs of VA ambulatory care.
Phibbs CS, Bhandari A, Yu W, Barnett PG.
This article reports how we matched Common Procedure Terminology (CPT) codes with Medicare payment rates and aggregate Veterans Affairs (VA) budget data to estimate the costs of every VA ambulatory encounter. Converting CPT codes to encounter-level costs was more complex than a simple match of Medicare reimbursements to CPT codes. About 40 percent of the CPT codes used in VA, representing about 20 percent of procedures, did not have a Medicare payment rate and required other cost estimates. Reconciling aggregated estimated costs to the VA budget allocations for outpatient care produced final VA cost estimates that were lower than projected Medicare reimbursements. The methods used to estimate costs for encounters could be replicated for other settings. They are potentially useful for any system that does not generate billing data, when CPT codes are simpler to collect than billing data, or when there is a need to standardize cost estimates across data sources.
PMID: 15095546

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Accessibility and acceptability of the Department of Veteran Affairs health care: diverse veterans' perspectives.
Damron-Rodriguez J, White-Kazemipour W, Washington D, Villa VM, Dhanani S, Harada ND.
OBJECTIVES: Diverse veteran's perspectives on the accessibility and acceptability of the Department of Veteran Affairs (VA) health services are presented. METHODS: The qualitative methodology uses 16 focus groups (N = 178) stratified by war cohort (World War II and Korean Conflict versus Vietnam War and Persian Gulf War) and four ethnic/racial categories (African American, Asian American, European American, Hispanic American). RESULTS: Five themes emerged regarding veterans' health care expectations: (1) better information regarding available services, (2) sense of deserved benefits, (3) concern about welfare stigma, (4) importance of physician attentiveness, and (5) staff respect for patients as veterans. Although veterans' ethnic/racial backgrounds differentiated their military experiences, it was the informants' veteran identity that framed what they expected of VA health services.

CONCLUSIONS: Accessibility and acceptability of VA health care is related to veterans' perspectives of the nature of their entitlement to service. Provider education and customer service strategies should consider the identified factors to increase access to VA as well as improve veterans' acceptance of the care.
PMID: 15080247

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Chemical and radiological toxicity of depleted uranium.
Sztajnkrycer MD, Otten EJ.
A by-product of the uranium enrichment process, depleted uranium (DU) contains approximately 40% of the radioactivity of natural uranium yet retains all of its chemical properties. After its use in the 1991 Gulf War, public concern increased regarding its potential radiotoxicant properties. Whereas in vitro and rodent data have suggested the potential for uranium-induced carcinogenesis, human cohort studies assessing the health effects of natural and DU have failed to validate these findings. Heavy-metal nephrotoxicity has not been noted in either animal studies or Gulf War veteran cohort studies despite markedly elevated urinary uranium excretion. No significant residual environmental contamination has been found in geographical areas exposed to DU. As such, although continued surveillance of exposed cohorts and environments (particularly water sources) are recommended, current data would support the position that DU poses neither a radiological nor chemical threat.
PMID: 15080241

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Shock to the system. Problems may force VA to forsake computer project.
Fong T.
PMID: 15124414

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Medicaid under the knife? Congress considering funding cuts in program.
Fong T.
PMID: 15077348

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We made a mistake.
Johnson C.
When Annals of Internal Medicine published a paper about the risk-management program at Veterans Affairs Medical Center, Lexington, Ky., readers were surprised at the facility's open policy regarding medication errors. Here's how health care leaders there put their liability on the line for better patient care.
PMID: 15127633

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Health care providers' perceptions of spirituality while caring for veterans.
Fletcher CE.
To determine health care providers' views on spirituality, its role in the health of patients, and barriers to discussing spiritual issues with patients, the author convened five focus groups at two Veterans Administration Medical Centers. Participants were nurses, physicians, social workers, psychologists, and chaplains. Common themes included (a) the lack of education for professionals regarding how

to address patients' spiritual needs; and (b) systems-related issues, including communication systems that do not function well, how spiritual needs are addressed on admission, support or lack thereof by hospital administrators, and lack of support for the spiritual needs of staff. The aging and illnesses of many current veterans plus the escalated potential of war highlight the importance of addressing veterans' spiritual needs.
PMID: 15068579

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Training family physicians for practice in Appalachia: 25 years of serving the health needs of east Tennesseans.
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PMID: 15077561 [PubMed - indexed for MEDLINE]

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Correlates of quality of life in older adult veterans.
Mowad L.
The purpose of this correlational study was to test theoretical propositions describing positive relationships between health promotion, sense of coherence, personal autonomy, and quality of life in older adult veterans and to explore their overall contribution to the prediction of quality of life. The sample consisted of 135 veterans aged 65 to 85 years who completed the Health-Promoting Lifestyle Profile, the Sense of Coherence-13 Scale, the Perceived Enactment of Autonomy Scale, and the Quality of Life Profile: Seniors Version, Short Scale. Health-promoting lifestyle, sense of coherence, and autonomy were positively correlated to quality of life. When the independent variables were subjected to a regression analysis, health-promoting lifestyle and autonomy explained 38% of the variance in quality of life.
PMID: 15068553